STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING 00 B. WING	10/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Recertification and State Licensure Survey. Survey dates: October 15, 16, 17 & 18, 2012 Facility number: 000070 Provider number: 155149 AIM number: 100266190 Survey team: Christi Davidson, RN-TC Connie Landman, RN Diana Zgonc, RN Lora Brettnacher, RN Census bed type: SNF: 2 SNF/NF: 81 Total: 83 Census payor type: Medicare: 10 Medicaid: 65 Other: 8 Total: 83 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 10/23/12 by Suzanne Williams, RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify the family and/or the physician for 1 of 36 residents reviewed for physician/family notification of a	F0157	The creation and submission of this Plan of Correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation of	11/04/2012

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	significant change. This change had the potential for requiring physician intervention which could have prevented his death (Resident #116). Findings include: Resident #116's record was reviewed on 10/16/2012 at 2:22 P.M. Resident #16 was admitted to this facility on 6/13/2012. Resident #116's diagnoses included, but were not limited to, diabetes, uncomplicated, type II, acute cerebral vascular disease(stroke), hemiplegia, depression, history of acute renal failure, history of prostate cancer insitu, history of metabolic acidosis, dysphagia, and hypertension. Resident #116 had been in another rehab facility following a stroke which occurred in May of 2012. This stroke affected the right side of his body. While at this facility he developed complications and was sent to an acute care hospital due to a mental status change and was treated for metabolic acidosis and acute renal failure secondary to volume depletion. The hospital's transfer report dated 6/13/2012 indicated both issues were resolved over the course of the hospital stay and Resident #116 was transferred to Harcourt Terrace in		regulation.This provider respectfully requests that the 2567L, Plan of Correction, be considered the Letter of Credible Allegation and respecfully requests an IDR on or after 11-4-12.F157 Notify of Changes (Injury/Decline/Room, etc)It is the practice of this facility to immediately inform resident; consult with the resident's physician; and it known the resident's legal representative or an interested family member when there is an accident infolving the resident which results in injury and has the potential for requiring physician intervnetion; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the facility as specified in 483.12(a)1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident #116's physician was notified of change in level of consciousness and change in condition. Resident #116 no longer resides at the facility.2. How will you identify other residents having the potential to be affected by these same deficient practices and what corrective action will be taken?All residents have the potential to be affected. All licensed nurses were inserviced by the Clinical Nurse Specialist on	

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	stable condition on 6/13/2012 to continue rehabilitation from the stroke. A nurses note dated 6/13/2012 indicated Resident #116 was alert and oriented, but hard to understand related to dysphagia, A nursing note dated 6/14/2012 indicated Resident #116 was alert to self only. A nurse's noted dated 7/4/2012 indicated Resident #116 was alert to self and environment, ambulated by wheelchair, was able to make needs known, and was in a happy mood that shift. A care plan dated 6/20/2012 indicated Resident #116 was a full code, had support from family, and his wife visited almost daily since admission. Discharge plans were for him to return home with his wife. Resident #116 had chosen to have life sustaining measures with approaches that included to call the emergency ambulance as needed and notify MD and family of condition changes. A nurse's note dated 7/7/2012 at 2:15 P.M. indicated, "Resident is less responsive than normal. BP (blood pressure) 90/62 P (pulse) 64 02 sat (oxygen saturation) on RA (room air) 93% Resp (respirations) 26. No signs		October 31, 2012, regarding physician notification, change of condition assessment, utilizing SBAR prior to sending residents to the hospital, utilizing vital sign assessment methods, and utilizing facility electronic medical record reports to give shift to shift report.3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?Charge Nurses will notify the physician/family of any changes in condition 24 hours a day/7 days per week. All licensed nurses were inserviced by the Clinical Nurse Specialist on October 31, 2012, regarding physician notification, change of condition assessment, utilizing SBAR prior to sending residents to the hospital, utilizing vital sign assessment methods, and utilizing facility electronic medical record reports to give shift to shift report DNS/Designee will montior physician orders for physician and family notification. DNS/Designee will monitor the facility electronic medical record facility activity report to ensure all resident change of condition and potential change of conditions are reported to physician and family, including vital signs out of range. Licensed staff not adhering to policy will receive education, disciplinary action up to and including termination.4. How will the corrective action(s) be monitored to ensure the deficient	

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	of acute pain. Opens eyes when nae [sic] is called. Answering service for (DR. named) called at this time. Awaiting return call from (Nurse Practitioner [NP] named)." A telephone order dated 7/7/12 at 3:00 P.M. indicated the NP gave orders to check Resident #116's vitals every 4 hours for 24 hours. This order indicated the problem was a change in LOC (level of conscience) and the intervention was the above order. The next two nursing notes were recorded as late entries on 7/8/2012 at 2:46 P.M. and 2:53 P.M. The late entry recorded on 7/8/2012 at 2:46 P.M. for 7/7/2012 at 3:34 P.M. indicated, "Resident is responding to voice and touch. He is pulling hand and arm away." The late entry dated 7/8/2012 at 2:53 P.M. for 7/7/2012 at 7:52 P.M. indicated, "Resident has some juice to drink, he is a little more cooperative at this time VS (vitals) are WNL (within normal limits), respirations unlabored, resting at this time." The vitals record indicated on 7/7/2012 at 7:49 P.M. Resident #116's vitals were: blood pressure 110/72, pulse 72, respirations 20, and oxygen saturations were 96%.		practice will not recur, ie, what quality assurance program will be put into place?The physician notification CQI tool will be used weekly x 4, bimonthly x 2, and quarterly thereafter, for at least 6 months. Action plans will be adjusted until 95% compliance is achieved.5. Date of compliance 11-4-12	

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The next nursing note dated 7/8/2012 at 12:00 A.M. indicated, "Res in bed asleep with HOB (head of bed) elevated. no s/sx (signs or symptoms) of distress/discomfort noted. res bed low with landing mat at bedside call light in reach, no behavior/agitation noted. spoke with wife earlier to inform her of res status. concerns of res not eating food during meal time."

The vitals record indicated on 7/8/2012 at 12:15 A.M., Resident #116's vitals were: blood pressure 78/60, respirations 20, no oxygen saturation was documented, no pulse was documented. According to the vitals document, the facility utilizes the acceptable ranges for blood pressure of 90-180/50-90.

The next vitals documented were at 2:15 A.M. pulse was 48, blood sugar was 362 mg/dl, and temperature was 97.7. Oxygen saturation or blood pressure were not documented.

The next nurse's note was dated 7/8/2012 at 3:08 A.M. This note indicated, "res in bed with HOB elevated. CNA (Certified Nursing Assistant) reported res breathing with difficulty, writer went in to assess res

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	et (and) respirations 22-24 per min. Accu check 362 mg/DL, writer put res on 2 L (Liters) oxygen per nursing measures. MD notified writer awaiting return call. upon awaiting return call from MD writer unable to obtain respiration no chest movement removed from bed et placed on hard surface CPR initiated per writer/nursing staff 911 called. after EMT (Emergency Medical Technicians) arrives et continued CPR writer called on-call manager to notify of res status. family/wife notified et family states they are on the way to facility spoke with (NP named)/(Dr. named) on call and order to release body to mortuary of choice, death certificate completed et given to mortician. Dr from (hospital named) to sign off on time of death per EMT personnel." During an interview on 10/17/2012 at 2:20 P.M., the facility's corporate clinical nurse consultant was asked to provide the resident's entire chart including doctor orders, doctor notification, care plans, hot charting, event charting, observation documents, progress notes, documentation of vitals, and any information regarding care given to Resident #116 when the first abnormal blood pressure was noted			

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	on 7/7/2012 at 7:49 P.M. through 2:15 A.M. when his pulse was documented as 48 beats per minute prior to his cardiac arrest. During an interview on 10/17/2012 at 2:51 P.M., the facility's corporate clinical nurse consultant indicated the doctor or family had not been notified of the abnormal blood pressure. During an interview on 10/18/2012 at 10:06 A.M., the NP, who was notified of Resident #116's level of consciousness (LOC) change and gave the order to monitor vitals every 4 hours for 24 hours, was questioned if she would have intervened if she had been notified of Resident #116's blood pressure dropping from 110/72 at 7:49 P.M. to 78/60 at 12:15 A.M. She replied, "If he was awake and talking with no other symptoms, I would have ordered stat labs. It just depended on what they told me. If he was not, I would have just sent him to the hospital." She indicated she did not remember the call or what they told her. During an interview on 10/18/2012 at 10:30 A.M., the Executive Director (ED) and the Director of Nursing (DON) reviewed the information surrounding Resident #116's death.			

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	The DON indicated the doctor should have been notified of the abnormal blood pressure. The ED indicated none of the staff who documented on this resident at the time in question were still employed, therefore not available for interviews. A current facility policy provided by the corporate nurse consultant on 3/16/12 at 3:50 P.M. indicated: It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely and effective intervention occurs. . .Acute Medical Change-any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. the licensed nurse in charge will notify the physician. . . The responsible party will be notified that there has been a change in the resident's condition and what steps are being taken. All nursing actions/interventions will be documented in the medical record as soon as possible after resident needs have been met. 3.1-5(a)			

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F0309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to thoroughly assess, treat, and ensure care was provided for a resident with a significant change in condition, with changes in level of consciousness and vital signs, for 1 of 2 residents who died and were reviewed for the prevention of death (Resident #116). Findings include: Resident #116's record was reviewed on 10/16/2012 at 2:22 P.M. Resident #16 was admitted to this facility on 6/13/2012. Resident #116's diagnoses included, but were not limited to, diabetes, uncomplicated, type II, acute cerebral vascular disease (stroke), hemiplegia, depression, history of acute renal failure, history of prostate cancer insitu, history of metabolic acidosis, dysphagia, and hypertension. Resident #116 had been in another rehab facility following a stroke which	F0309	F309 Provide Care and Services for Highest Well BeingIt is the practice of this facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident #116's physician was notified of change of level of consciousness and again for change of condition. Resident #116's plan of care was followed as CPR and full code was administered and initiated per licensed nursing staff. Resident #116 no longer resides at the facility.2. How will you identify other residents having the potential to be affected by these same deficient practicies and what corrective action will be taken?All residents have the potential to be affected. All licensed nurses were inserviced by the Clinical Nurse Specialist on October 31, 2012, regarding	11/04/2012

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	occurred in May of 2012. This stroke affected the right side of his body. While at this facility he developed complications and was sent to an acute care hospital due to a mental status change and was treated for metabolic acidosis and acute renal failure secondary to volume depletion. The hospital's transfer report dated 6/13/2012 indicated both issues were resolved over the course of the hospital stay and Resident #116 was transferred to Harcourt Terrace in stable condition on 6/13/2012 to continue rehabilitation from the stroke. A Speech Therapy (ST) note dated 6/14/2012 indicated Resident #116's goal was to complete self-care and activities of daily living (ADLs) with minimal assistance within the home in order to return home safely with his spouse. His rehabilitation potential was good due to he was independent in prior activities of daily living and self care and his improving medical condition. A Physical Therapy (PT) discharge summary dated 7/6/2012 indicated his prognosis for further progress was good. A Speech Therapy (ST) note dated 7/5/2012 indicated Resident #116's prognosis for further progress was good due to the strong support of his significant		physician notification, change of condition assessment, utilizing SBAR prior to sending residents to the hospital, utilizing vital sign assessment methods, and utilizing facility electronic medical record reports to give shift to shift report.3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?Charge Nurses will notify the physician/family of any changes in condition 24 hours a day/7 days per week. All licensed nurses were inserviced by the Clinical Nurse Specialist on October 31, 2012, regarding physician notification, change of condition assessment, utilizing SBAR prior to sending residents to the hospital, utilizing vital sign assessment methods, and utilizing facility electronic medical record reports to give shift to shift report DNS/Designee will montior physician orders for physician and family notification. DNS/Designee will monitor the facility electronic medical record facility activity report to ensure all resident change of condition and potential change of conditions are reported to physician and family, including vital signs out of range. Licensed staff not adhering to policy will receive education, disciplinary action up to and including termination.4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie, what	

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	other. A Social Service Note dated 6/21/2012 indicated a meeting was held with Resident #116, his wife, and IDT (interdisciplinary team). During this meeting Resident #116's wife was informed of the progress being made in therapy and the goals still to accomplish. Resident #116's wife indicated in this meeting she wanted her husband home even if he was unable to be independent. She was considering retiring to care for her husband. A nurses note dated 6/13/2012 indicated Resident #116 was alert and oriented, but hard to understand related to dysphagia, A nursing note dated 6/14/2012 indicated Resident #116 was alert to self only. A nurse's noted dated 7/4/2012 indicated Resident #116 was alert to self and environment, ambulated by wheelchair, was able to make needs known, and was in a happy mood that shift. A care plan dated 6/20/2012 indicated Resident #116 was a full code, had support from family, and his wife visited almost daily since admission. Discharge plans were for him to return home with his wife. Resident		quality assurance program will be put into place?The physician notification CQI tool will be used weekly x 4, bimonthly x 2, and quarterly thereafter, for at least 6 months. Action plans will be adjusted until 95% compliance is achieved.5. Date of compliance 11-4-12	

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	#116 had chosen to have life sustaining measures with approaches that included to call the emergency ambulance as needed and notify MD and family of condition changes. A nurse's note dated 7/7/2012 at 2:15 P.M. indicated, "Resident is less responsive than normal. BP (blood pressure) 90/62 P (pulse) 64 02 sat (oxygen saturation) on RA (room air) 93% Resp (respirations) 26. No signs of acute pain. Opens eyes when nae [sic] is called. Answering service for (DR. named) called at this time. Awaiting return call from (Nurse Practitioner [NP] named)." A telephone order dated 7/7/12 at 3:00 P.M. indicated the NP gave orders to check Resident #116's vitals every 4 hours for 24 hours. This order indicated the problem was a change in LOC (level of conscience) and the intervention was the above order. The next two nursing notes were recorded as late entries on 7/8/2012 at 2:46 P.M. and 2:53 P.M. The late entry recorded on 7/8/2012 at 2:46 P.M. for 7/7/2012 at 3:34 P.M. indicated, "Resident is responding to voice and touch. He is pulling hand and arm away." The late entry dated 7/8/2012 at 2:53 P.M. for 7/7/2012 at			

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	155149	A. BUILDING 00 B. WING	10/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

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	7:52 P.M. indicated, "Resident has some juice to drink, he is a little more cooperative at this time VS (vitals) are WNL (within normal limits), respirations unlabored, resting at this time." The vitals record indicated on 7/7/2012 at 7:49 P.M. Resident #116's vitals were: blood pressure 110/72, pulse 72, respirations 20, and oxygen saturations were 96%. The next nursing note dated 7/8/2012 at 12:00 A.M. indicated, "Res in bed asleep with HOB (head of bed) elevated. no s/sx (signs or symptoms) of distress/discomfort noted. res bed low with landing mat at bedside call light in reach, no behavior/agitation noted. spoke with wife earlier to inform her of res status. concerns of res not eating food during meal time." The vitals record indicated on 7/8/2012 at 12:15 A.M., Resident #116's vitals were: blood pressure 78/60, respirations 20, no oxygen saturation was documented, no pulse was documented. According to the vitals document, the facility utilizes the acceptable ranges for blood pressure of 90-180/50-90.			

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	The next vitals documented were at 2:15 A.M. pulse was 48, blood sugar was 362 mg/dl, and temperature was 97.7. Oxygen saturation or blood pressure were not documented. The next nurse's note was dated 7/8/2012 at 3:08 A.M. This note indicated, "res in bed with HOB elevated. CNA (Certified Nursing Assistant) reported res breathing with difficulty, writer went in to assess res et (and) respirations 22-24 per min. Accu check 362 mg/DL, writer put res on 2 L (Liters) oxygen per nursing measures. MD notified writer awaiting return call. upon awaiting return call from MD writer unable to obtain respiration no chest movement removed from bed et placed on hard surface CPR initiated per writer/nursing staff 911 called. after EMT (Emergency Medical Technicians) arrives et continued CPR writer called on-call manager to notify of res status. family/wife notified et family states they are on the way to facility spoke with (NP named)/(Dr. named) on call and order to release body to mortuary of choice, death certificate completed et given to mortician. Dr from (hospital named) to sign off on time of death per EMT personnel."			

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	During an interview on 10/17/2012 at 2:20 P.M., the facility's corporate clinical nurse consultant was asked to provide the resident's entire chart including doctor orders, doctor notification, care plans, hot charting, event charting, observation documents, progress notes, documentation of vitals, and any information regarding care given to Resident #116 when the first abnormal blood pressure was noted on 7/7/2012 at 7:49 P.M. through 2:15 A.M. when his pulse was documented as 48 beats per minute prior to his cardiac arrest. During an interview on 10/17/2012 at 2:51 P.M., the facility's corporate clinical nurse consultant indicated the doctor had not been notified of the abnormal blood pressure. Documentation of a pulse taken at that time or an oxygen saturation level was not available. During an interview on 10/18/2012 at 10:06 A.M., the NP, who was notified of Resident #116's level of consciousness change and gave the order to monitor vitals every 4 hours for 24 hours, was questioned of her expectations of the vitals she expected the nurse to monitor. She replied, "Temp, respirations, pulse, 02			

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	sats, and if it was due to a neurological change, neuro checks." She indicated she could not remember the call or exactly what she was told. When questioned if she would have intervened if she had been notified of Resident #116's blood pressure dropping from 110/72 at 7:49 P.M. to 78/60 at 12:15 A.M., she replied, "If he was awake and talking with no other symptoms, I would have ordered stat labs. It just depended on what they told me. If he was not, I would have just sent him to the hospital." During an interview on 10/17/2012 at 2:11 P.M., the supervisor at the funeral home where Resident #116's body was taken indicated the death certificate listed the causes of death as: a. stroke on left brain, b. essential hypertension, c. diabetes mellitus type II, d. acute renal failure. Cause of death part two: prostate cancer localized six years. He indicated an autopsy was not done. During an interview on 10/18/2012 at 10:30 A.M., the Executive Director (ED) and the Director of Nursing (DON) reviewed the information surrounding Resident #116's death. The DON indicated it would depend on what was going on with the			

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	resident which vitals he would have expected the nurse to obtain. He did not feel oxygen saturation was a necessary vital. He indicated a pulse should have been taken and the doctor should have been notified of the abnormal blood pressure. There was not documentation of a mental status at the time of the abnormal vitals, but if the resident was being monitored for a change in mental status, the DON indicated "then maybe not neurological checks but at least mental status assessments would be expected." The ED indicated none of the staff who documented on this resident at the time in question were still employed, therefore not available for interviews. 3.1-37(a)			